STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 20,894
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Office of Vermont Health Access (OVHA) denying her request for an exception under M108 for coverage of a gym membership under the Medicaid program. The issue is whether the petitioner has shown that serious detrimental health consequences will occur if she does not receive such coverage.

FINDINGS OF FACT

1. The petitioner is a fifty-nine-year-old woman with a history of back problems, obesity, and breast cancer. In June 2007 she underwent a mastectomy. In January 2007, and again in April 2007, the petitioner's primary care doctor requested Medicaid coverage for a gym membership to treat her back pain.

2. Following the Department's denial of this request and the petitioner's appeal on June 1, 2007, the matter was continued for several weeks to allow the petitioner to submit additional evidence. At a status conference held by phone on

September 21, 2007, the petitioner indicated that she had no further evidence to submit.

3. The essential parts of the letters submitted by the petitioner's doctor in support of her request for a gym membership for the petitioner, respectively dated January 4 and April 7, 2007, are reproduced below.

> [Petitioner] has been my patient since May, 2002. She has a long history of chronic low back pain. In 2003 she had worsening of this back pain to the point of almost being debilitating. Since that time it has waxed and waned and she has been through several different courses of treatment. She went through physical therapy in 2003 and then again in 2006. She also joined a gym sometime between those two courses of physical therapy. She found the fitness program at the gym extremely helpful for her back. She was able to do it almost on a daily basis and found that it greatly decreased her back pain, much more so than the physical therapy. She is maintained on a low dose of pain medication for her back but even with that it does not alleviate the pain. She would like to join the gym rather than undergo another course of physical therapy as the physical therapy was less effective for her back pain.
>
> In addition, she notes that the membership for the gym is for 3 months would be about $100, whereas the course of physical therapy was approximately $1,000.
>
> I am writing to you to request that you cover her membership at the gym rather than having her undergo another course of physical therapy as the gym was much more effective in treating her back pain, as well as being much less expensive.
>
> * * *
>
> I wrote a letter requesting coverage for a gym membership for [petitioner] in lieu of physical therapy for the patient's debilitating low back pain. She has found a fitness program at a particular gym in Brattleboro to be more helpful than two courses of

> physical therapy. I did send a letter dated January 4, 2007, as well as partially filled out a form. Apparently, because I checked that serious detrimental health consequences did not apply in the case, her request was denied. I guess this is a matter of how one defines “serious detrimental health consequences”. I was thinking of death and being bedridden as serious health consequences” are. She is morbidly obese and has been unable to exercise due to the back pain. This of course is a vicious cycle because the weight contributes to her back pain. She is limited in her walking because of her back pain. She does also have elevated liver function tests which could very well be related to her abdominal adipose which could eventually be a serious health consequence. I am sure that her weight would decrease if she had less low back pain enabling her to be more physically active. Her obesity certainly is a serious health problem.
>
> Please call me if you have any questions about this. She does continue to have to take pain medication chronically because of her back pain which also is adversely impacting her health. The program at the gym truly has been the only treatment that in the past has significantly helped her back pain to improve. Please consider your denial of this.

4. The record in this matter also contains a specific referral for "pool therapy" from an orthopedist who saw the petitioner in May 2004. There are also reports from a physical therapist on October 10, 2006 that the petitioner had been seen in physical therapy "for 7 visits between 9/11/06 and 10/6/06", and that she was "benefiting from her work in the pool", and that she had reported that she was "nearly painfree" (sic). The plan of further treatment outlined in that report was "to continue her work in the pool

and gradually move into an exercise program in the clinic that she can transfer to a gym environment".

5. Another PT report dated November 7, 2006 stated that the petitioner had attended 4 more "pool sessions" in October 2006, but had terminated these sessions following a disagreement with the therapist over the need for periodic evaluations of her progress as required by Medicaid regulations. It was also noted that the petitioner intended to enroll in a gym on her own.

6. The petitioner maintains that she lost twenty pounds "from walking at the gym", apparently on a treadmill. She states that the PT facility where she received her pool therapy was "dirty" and overpriced.

7. As noted above, the petitioner has submitted no medical evidence since her doctor's last request in early April. Considering the fact that she had surgery in June, it is unclear whether her doctor would continue to support an unsupervised rehabilitation regimen that consists only of a gym membership. After reviewing the medical evidence, the Department's medical consultants feel that an exercise program alone is insufficient for the petitioner. They have recommended a comprehensive evaluation and treatment program for the petitioner's chronic pain and weight problems. At

this time, there is no indication whatsoever in the record that the petitioner's doctor disagrees with this approach.

ORDER

The Department's decision is affirmed.

REASONS

There is no dispute in this matter that gym memberships and exercise equipment are not primarily medical in nature and ordinarily are not covered under Medicaid. See W.A.M. § M840.6. However, OVHA has a procedure for requesting exceptions to this and other areas of non-coverage, which requires the recipient to provide information about her situation and supporting documentation. W.A.M. § M108. Under this provision OVHA must review the available medical information submitted in relation to a number of criteria as set forth below:

1. Are there extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service or item were not provided?

2. Does the service or item fit within a category or subcategory of services offered by the Vermont Medicaid program for adults?

3. Has the service or item been identified in rule as not covered, and has new evidence about efficacy been presented or discovered?

4. Is the service or item consistent with the objective of Title XIX?

5. Is there a rational basis for excluding coverage of the service or item? The purpose of this criterion is to ensure that the department does not arbitrarily deny coverage for a service or item. The department may not deny an individual coverage of a service or item solely based on its cost.

6. Is the service or item experimental or investigational?

7. Have the medical appropriateness and efficacy of the service or item been demonstrated in the literature or by experts in the field?

8. Are there less expensive, medically appropriate alternatives not covered or not generally available?

9. Is FDA approval required, and if so, has the service or item been approved?

10. Is the service or item primarily and customarily used to serve a medical purpose, and is it generally not useful to an individual in the absence of an illness, injury, or disability?

In several past decisions, including one that was affirmed by the Vermont Supreme Court, the Board has extensively examined the criteria of M108 as it applies to non-covered items and services. See e.g. Fair Hearing No. 16,223; aff'd; Cameron v. D.S.W., Vermont Supreme Court Docket No. 2000-339 (8/23/01). It has held that M108 gives OVHA the authority to make exceptions for Medicaid coverage in cases which he or she deems meet the above criteria, and

that the Board may only overturn an M108 decision if it is shown to be arbitrary, unreasonable, or otherwise an abuse of discretion.

In this case, the Department's rationale denying coverage is extremely thorough and detailed. Although a gym membership would certainly be cheaper, as noted above, the Department has instead offered the petitioner coverage for a comprehensive evaluation and treatment program aimed at comprehensively addressing her problems with excessive weight and back pain. Moreover, there is no indication that the petitioner's doctor would not support this option as a first resort.[1] In light of this, it cannot be concluded that the Department's decision denying the petitioner's request for a gym membership is in any way contrary to M108, especially criterion no. 1 (*supra*), in that it has not been shown the petitioner will suffer "serious detrimental health consequences" if she cannot obtain a gym membership.

[1] The petitioner was specifically advised that she could reapply for coverage for a gym membership if her doctor indicated she did not support the Department's rationale.

Thus, the Board is bound at this time to affirm the Department's decision. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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